STATE OF IDAHO
DEPARTMENT OF HEALTH & WELFARE
Bureau of Laboratories
2220 Old Penitentiary Road, Boise, ID 83712

DO NOT WRITE IN THIS SPACE

DHW Lab No.
Date Received

REQUEST FOR: **IDENTIFICATION** **CONFIRMATION** **SEROTYPING**

OTHER (Specify) _____

The following information is REQUIRED on all cultures referred to our laboratories for identification. FILL IN ALL ITEMS.

Please Return Report To:
Requestor
Street Address
City, State Zip

Attending Physician | Phone No

CULTURE SOURCE

❑ Blood ❑ Sputum ❑ Urine ❑ Spinal Fluid
❑ Skin ❑ Stool ❑ Throat Wound (Site)
Exudate (Site) _____ Other (Specify) _____

Specific Organism Suspected

CULTURE SUBMITTED

Submitted On
❑ Trypticase Soy Agar Slant
❑ Chocolate Agar Slant ❑ Other (Specify) _____

No. Times Isolated | No. Times Transferred | Growth in O_2 ❑ **Yes** ❑ **No**

Special Growth Requirements

Predominant Organism Isolated

Other Organisms Isolated

Biochemical Tests

PATIENT INFORMATION

Date Specimen Taken

Patient Name or Number

City or County

Date of Birth | Occupation | ❑ **Male** ❑ **Female**

Clinical Diagnosis

Associated Illness

Date of Onset | Fatal ❑ **Yes** ❑ **No**

Epidemiological Data (If Any)
❑ Isolated Case
❑ Suspected Carrier
❑ Hospital Acquired Infection
❑ Suspected Foodborne Outbreak

Animal Contacts (Specify)

TRAVEL: Out of USA | Date
Within of USA | Date

Brief Clinical History

Do Not Write Below This Line

Identified As

Additional Report

Date Reported

HWH - 0228